OBSTETRICS.

UNDER THE CHARGE OF

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VERSION WITH ONE FOOT.

NAGEL (*Archiv für Gynäkologie*, Band xliv., Heft 1) contributes an article relative to version with one foot, and discusses which one is best to bring down first. As a result of his observations in thirty cases of his own, and from a consideration of many reported by other authorities, he concludes that in order to complete version of a child *in utero*, it is indifferent which foot is seized. If one has in view the fact that the drawn down and extended leg shall lie, immediately after complete version, forward, behind the symphysis, one will generally obtain this if the *under* leg in dorso-anterior and the *upper* one in dorso-posterior position is drawn down. If there has been produced through version an incomplete foot presentation with posterior leg extended, it will probably turn forward in such a manner that the back of the child slides by the promontory. If in such cases as the one last mentioned, it is necessary to hasten the birth of the child, such turning of the breech of the child on its long axis must be favored, as will bring the extended leg forward.

DECIDUO-CELLULAR SARCOMA AND DECIDUAL TUMORS.

SÄNGER (*Archiv für Gynäkologie*, Band xliv., Heft 1, p. 89) takes as his text the case of a married woman aged twenty-three years, who, after an injury received in stepping from a railroad train, aborted incompletely in the eighth week of gestation. She suffered from hemorrhage continuously for three weeks, at the end of which time fever ensued, with symptoms of septi-cæmia. The uterus was curetted, after which the fever and hemorrhage ceased; but the pulse remained about 100. The woman was confined to her bed for five months, the convalescence being protracted by a diffuse parametritic exudation. A progressive enlargement of the uterus was now noticed, without tenderness and purulent discharge, and the patient was compelled to return to bed on account of fever and severe pain in the left hypochondrium. Soon there suddenly appeared in the right iliac fossa a soft, elastic, painful tumor as large as a goose-egg. This was suspected to be an abscess occurring during a chronic septic infection, and on this supposition was opened. No

pus was found, but a fungoid, spongy mass which was removed with the fingers and sharp spoon, exposing the bone beneath. Under the microscope the removed tissue consisted of cellular débris, with large nucleated round cells intermixed with small spindle-shaped cells and numerous small apoplexias. No tubercle bacilli could be found. There were no signs of pulmonary tubercular infection. The uterus was now as large as in a normal pregnancy of three or four months' duration. The patient was sent to the surgical department, but, owing to the uncertainty of the diagnosis, no operation was performed. She became rapidly dyspnœic, and finally died from exhaustion. At time of death there was orthopnœa.

The autopsy showed the uterus adherent on left side, and filled with spongy, dark-purple masses varying in size from a nut to an apple. Masses were classified as sarcoma telangiectodes, and most resembled mycosis fungoides of the skin. The uterine mucous membrane was not penetrated by the diseased masses. Metastatic masses were found in the iliac fossa, lungs, diaphragm, and ribs The microscope showed in the tissues small hemorrhagic foci and large nucleated round cells closely resembling the giant decidual cells; these latter seemed the earliest and simplest elements. The decidua apparently was the starting-point, the abortion being perhaps the initial lesion.

The forms of sarcoma now recognized may all be traced back to cells of mesoblastic origin and their products. Sarcomatous degeneration of the cells of the inter-glandular tissue of the mucosa uteri, according to Virchow, is divided into globo-cellular, fuso-cellular, and myxo-sarcoma, together with a mixed formation—sarcoma carcinomatodes. To these should be added sarcoma deciduo-cellular, sarcoma of the mucosa uteri transformed into decidua. In ectopic pregnancy, as is well known, the connective-tissue cells of the mucous membrane and muscular coat of the tubes, together with the serosa peritonei, undergo this transformation. During pregnancy the tissues of the sexual organs receive an immense impulse toward new formations, and conditions obtaining in the fœtal tissues may be impressed upon and transplanted to those of the mother. There may also be an infection of micro-organisms, as in many cases infectious disease of the decidua preceded the swelling. The diagnosis is based on the hemorrhage and ichorous discharge. These symptoms following a shorter or longer time after birth would make one suspect the presence of a deciduo-cellular sarcoma, especially if they return after complete evacuation of the uterus of all fœtal remains. A microscopic examination of fragments taken from the uterus by the finger should be made.

Regarding treatment, the author states that this variety of sarcoma is regarded as malignant; its early and accurate diagnosis is therefore of great importance. Complete extirpation is the only treatment worth attempting.

Recurrent Tubal Pregnancy in the Same Woman.

Abel (*Archiv für Gynäk.*, Band xliv., Heft 1, p. 55) contributes an article on the above-named subject. In regard to the causation of recurrent or single tubal pregnancy, most authors ascribe it to causes other than affections

of the tubes, and some even regard the contractions of their lumen as secondary in importance. Virchow assigns as a cause peritonitis and pseudo-membranous adhesions with constriction of the affected tube. Spiegelberg speaks of swelling of the tubal mucous membrane and obstructive collection of secretions. Klob mentions hernia of the mucous membrane and consequent arrest of peristalsis; or polyps of the uterine end may obstruct the ovum in its passage. It is also said that deficient, or absent, motion of the cilia is a cause of delay in the passage of the ovum, so that it finally grows too large for further progress. Any or all of these causes may at times be present, but they are not sufficient to account for a double recurrent tubal gestation. An abnormal formation of the tube, due to defect in embryonic development is the common source, and it affects both tubes equally. Freund's researches have shown that the tubes, after the union of the middle parts of Müller's ducts has formed the uterus, show a spiral, corkscrew-like twist, involving the whole tube. This occurs during the descent of the duct. When this has reached its greatest length, the turns begin to smooth themselves laterally from the uterus. These turns may remain as a permanent arrest of development, the surroundings being in no way involved and no trace of perisalpingitis or pelviperitonitis can be found. The condition may be often seen in the bodies of children. Thus any healthy woman is liable to a tubal pregnancy from her tubes remaining in an infantile state and the pregnancy be physiological. Again, the tubal canal does not always run in the middle of the tube cylinder; its course may be most devious, approaching and receding from the surface of the tube, which thus having walls of unequal thickness and resistance, the growing ovum distends it at the point of least resistance, and may thus be arrested in its progress. Another antecedent cause may be found in the so-called diverticulum of the tubal canal. The ovum may be entangled therein. To establish a diagnosis of single or recurrent tubal pregnancy, special importance attaches to the extension of a decidua from the uterus, though its absence is no proof that the gestation does not exist. A microscopic examination of the membrane is essential, though it is not certain that from it its extra-uterine character can be determined certainly. In various conditions membranes are thrown off from the uterus, thus: 1st. In extra-uterine pregnancy. 2d. Dysmenorrhœa membranacea. 3d. In intra-uterine pregnancy with abortion. In the first, the cellular part of the gland layer is fully differentiated, the inner layer is extended, the outer remains in the uterus. In the second, all the elements of the normal mucous membrane are cast off. On its surface is normal epithelium; the deep glands have their epithelium unaltered. All sorts of cells are found in their connecting tissues, and foci of infiltration abound. In the third, one finds either ovular débris or membranes showing the unmistakable evidences of pregnancy. The chief difference between the decidua of extra-uterine pregnancy and that of dysmenorrhœic membrane lies in the presence or absence of glands.

The treatment of this condition is laparotomy and removal of the sac. At the time the other tube should be examined, and if found to be spiral or twisted it should also be removed. Neither injection of the sac nor electro-puncture gives any positive assurance that subsequent rupture and hemorrhage may not occur.

Uterus Subseptus.

Cepinsky (*Centralblatt für Gynäkologie*, 1893, No. 33) reports the details of an interesting case of a double vagina in a woman twenty-six years of age. Menstruation regular. On examination the external genitals were found normal. The introitus vaginæ was not median, but by the side of the right labium majus. Hymen gone. Near the introitus was discovered a second opening 50 mm. broad, surrounded by a fringe of mucous membrane, through which a sound was passed into a second vagina, narrower than the first, but otherwise perfect. From either a sound could be introduced into the uterus, each vagina having a separate and perfect portio vaginæ uteri. Whether the division that completely separated these vaginæ extended throughout the uterine cavity could not be determined. The uterus was of normal size. Coitus easy and normal. A year later the patient returned for advice, complaining of irregular hemorrhage from the genitals accompanied by uterine pain. Had not menstruated for ten weeks. Examination showed the old anomaly with bleeding from the small opening of the left vagina. In the right vagina the os was open and there was hemorrhage therefrom. As the vaginal vault was pressed with the speculum a segment of fœtal membrane was observed to pass out of the os. Corpus uteri enlarged and soft. Abortion occurred on the following day, the ovum being the size of a plum, and in it an embryo three centimetres long was found. Ten days after the abortion, for experiment, milk was injected through the left cervix into the uterine cavity and this was observed to flow out through the right os.

GYNECOLOGY.

UNDER THE CHARGE OF

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The Curative Effect of Cœliotomy on Peritoneal Tuberculosis.

Warnek (*Centralblatt für Gynäkologie*, 1893, No. 50), after reviewing all the evidence in favor of the cure of tuberculous peritonitis by simple abdominal incision, with or without drainage, arrives at the conclusion that whenever the cavity is opened the peritoneum undergoes a certain amount of irritation, due to the change in its physiological condition caused by the entrance of air and the lowering of its normal temperature. In the case of various manipulations of the abdominal contents, by irrigation, sponging, the separation of adhesions, etc., an additional element of irritation is introduced, which is manifested not only by congestion of the serous surface, but by the subsequent formation of adhesions, which may in time be entirely absorbed, as shown by secondary operations. It is well known that in cases of ascites due to secondary papillary or carcinomatous growths on the peritoneum, the fluid may